Senate Bill No. 1702

Passed the Senate August 31, 2006

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Secretary of the Senate

Passed the Assembly August 31, 2006

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Chief Clerk of the Assembly

This bill was received by the Governor this _____ day of _____, 2006, at _____ o'clock ___M.

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Private Secretary of the Governor

CHAPTER _____

An act to amend Section 1373.62 of the Health and Safety Code, to amend Sections 10127.15, 12712.5, and 12725 of the Insurance Code, and to amend and supplement the Budget Act of 2006 (Chapter 47 of the Statutes of 2006) by adding Item 4280-112-0236 to Section 2.00 of that act, relating to health care coverage, making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 1702, Speier. Health care coverage.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Under existing law, a health care service plan and a health insurer are required to offer a standard benefit plan, as specified, pursuant to a pilot program ending on September 1, 2007. Existing law requires the Managed Risk Medical Insurance Board to make payments from the Major Risk Medical Insurance Fund, which is continuously appropriated, to plans and insurers for the provision of health care services under the standard benefit plan.

This bill would extend the duration of the pilot program to December 31, 2007, and would add a provision to the Budget Act of 2006 to transfer $4,000,000 from the unallocated account in the Cigarette and Tobacco Products Surtax Fund to the Major Risk Medical Insurance Fund. Because the bill would increase the amount of revenue in the fund and extend the time during which the board would make payments from it, the bill would make an appropriation. The bill would also impose a state-mandated local program by extending the requirements of the pilot program with respect to health care service plans.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1373.62 of the Health and Safety Code is amended to read:

1373.62. (a) (1) This section shall apply only to a health care service plan offering hospital, medical, or surgical benefits in the individual market in California and shall not apply to a specialized health care service plan, a health care service plan contract in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), a health care service plan conversion contract offered pursuant to Section 1373.6, or a health care service plan contract in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code).

(2) A local initiative, as defined in subdivision (v) of Section 53810 of Title 22 of the California Code of Regulations, that is awarded a contract by the State Department of Health Services pursuant to subdivision (b) of Section 53800 of Title 22 of the California Code of Regulations shall not be subject to the requirements of this section.

(b) For the purposes of this section, "program" means the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code).

(c) (1) Each health care service plan subject to this section shall offer a standard benefit plan. The calendar year limit on benefits under the plan shall be at least two hundred thousand dollars ($200,000), and the lifetime maximum benefit under the plan shall be at least seven hundred fifty thousand dollars ($750,000). No health care service plan is required to provide calendar year benefits or a lifetime maximum benefit under the plan that exceed these limits. In calculating the calendar year and lifetime maximum benefits for any person receiving coverage through a standard benefit plan, the health care service plan shall not include any health care benefits or services that person received while enrolled in the program.

(2) The standard benefit plan of a health care service plan participating in the program shall be the same benefit design it offers through the program, except for the annual limit required under paragraph (1). If the health care service plan offers more than one benefit design in the program, it shall offer only one of those benefit designs as its standard benefit plan.

(3) (A) The standard benefit plan of a health care service plan that is not a participating health plan within the program shall be any one benefit design that is offered through the program by a health care service plan participating in the program, except for the annual limit required under paragraph (1).

(B) A health care service plan that is not a participating health plan in the program that is under common ownership with, is affiliated with, or files consolidated income tax returns with, a health insurer that is also an insurer in the individual market may satisfy the requirements of this section and Section 10127.15 of the Insurance Code if either the plan or insurer offers a standard benefit plan.

(C) A health care service plan that is not a participating health plan in the program that is under common ownership with, is affiliated with, or files consolidated income tax returns with, a health insurer that is in the individual market and that is a participating health plan in the program is exempt from the provisions of this section if the insurer meets the requirements of Section 10127.15 of the Insurance Code in offering a standard benefit plan.

(d) (1) A health care service plan may not reject an application for coverage under its standard benefit plan for an individual who meets any of the following criteria:

(A) Applies for coverage within 63 days of the termination date of his or her previous coverage under the program if the individual has had continuous coverage under the program for a period of 36 consecutive months.

(B) Has been enrolled in a standard benefit plan, moves to an area within the state that is not in the service area of the health care service plan or health insurer he or she has chosen, and applies for coverage within 63 days of the termination date of his or her previous coverage.

(C) Has been enrolled in a standard benefit plan that is no longer available where he or she resides, and applies for coverage

within 63 days of the termination date of his or her previous coverage.

(2) Notwithstanding any other provision of this section, a health care service plan is not required by this section to accept an application for coverage under its standard benefit plan for any individual who is eligible for Part A and Part B of Medicare at the time of application and who is not on Medicare solely because of end-stage renal disease.

(e) The amount paid by an individual for the standard benefit plan shall be 110 percent of the contribution the individual would pay in the program for the benefit design providing the same coverage, using the same methodology in effect on July 1, 2002, for calculating the rates in the program. If a health care service plan offers calendar year and lifetime maximum benefits in its standard benefit plan that exceed those in the benefit design offered through the program, it may not increase the amount paid by the individual for the standard benefit plan. The limitation on the amount paid by an individual pursuant to this section for a standard benefit plan shall not apply to any individual who is eligible for Part A and Part B of Medicare and who is not on Medicare solely because of end-stage renal disease.

(f) (1) Prior to offering a health benefit plan contract pursuant to this section, every health care service plan shall file a notice of material modification pursuant to Section 1352. Prior to renewing the contract, the plan shall file an amendment or a notice of material modification, as appropriate, pursuant to Section 1352.

(2) Prior to making any changes in the premium charged for its standard benefit plan, the health care service plan shall file an amendment in accordance with the provisions of Section 1352 and shall include a statement certifying the plan is in compliance with subdivision (e).

(3) All other changes to a plan contract that was previously filed with the director shall be filed as an amendment in accordance with the provisions of Section 1352, unless the change otherwise would require the filing of a material modification.

(g) (1) Each health care service plan shall report to the Managed Risk Medical Insurance Board the amount it has expended for health care services for individuals covered under a

standard benefit plan under this section and the total amount of individual payments it has charged individuals for the standard benefit plan. The board shall establish by regulation the format for these reports. The report shall be prepared for each of the following reporting periods and shall be submitted within 12 months of the final date of the reporting period:

(A) September 1, 2003, to December 31, 2003, inclusive.

(B) January 1, 2004, to December 31, 2004, inclusive.

(C) January 1, 2005, to December 31, 2005, inclusive.

(D) January 1, 2006, to December 31, 2006, inclusive.

(E) January 1, 2007, to December 31, 2007, inclusive.

(2) "Health care services" means the aggregate health care expenses paid by the health care service plan or insurer during the reporting period plus the aggregate value of the standard monthly administrative fee. Health care expenses do not include costs that have been incurred but not reported by the health care service plan. The calculation of health care expenses shall be consistent with the methodology used on July 1, 2002, to calculate those expenses for participating health plans in the program. The "standard monthly administrative fee" is the average monthly, per person administrative fee paid by the program to participating health plans during the reporting period.

(3) The "total amount of individual payments" is the aggregate of the monthly individual payments charged by the health care service plan during the reporting period. The calculation of the total amount of individual payments charged shall be consistent with the methodology used on July 1, 2002, to calculate subscriber contributions in the program. The Managed Risk Medical Insurance Board shall by regulation establish the format for submitting documentation of the individual payments.

(4) The Managed Risk Medical Insurance Board may verify the health care expenses incurred by a health care service plan and the individual payments received by the plan. The verification shall include assurance that the individual was enrolled in the standard benefit plan during the reporting period in which the health care service plan paid health care expenses on the individual's behalf, and that the expenses reported are consistent with the standard benefit plan.

(h) (1) The program shall pay each health care service plan an amount that is equal to one-half of the difference between the

total aggregate amount the health care service plan expended for health care services for individuals covered under a standard benefit plan who have had 36 consecutive months of coverage under the program and the total aggregate amount of individual payments charged to those individuals who have had continuous coverage under the program for a period of 36 consecutive months. For purposes of determining the amount the program shall pay each health care service plan, the total aggregate amount the health care service plan expended and the total aggregate amount of individual payments shall not include amounts paid by or on behalf of an individual who is eligible for Medicare Part A and Medicare Part B and who is not on Medicare solely because of end-stage renal disease. The program shall make this payment from the Major Risk Medical Insurance Fund or from any funds appropriated in the annual Budget Act or by another statute to the program for the purposes of this section. The state shall not be liable for any amount in excess of the moneys in the Major Risk Medical Insurance Fund or other funds that were appropriated for the purposes of this section. If the state fails to expend, pursuant to this section, sufficient funds for the state's contribution amount to any health care service plan, the health care service plan may increase the monthly payments that individuals are required to pay for any standard benefit plan to the amount that the Managed Risk Medical Insurance Board would charge without a state subsidy for the same plan issued to the same individual within the program.

(2) The Managed Risk Medical Insurance Board shall make a biannual interim payment to each health care service plan providing coverage pursuant to this section. For the first two reporting periods described in this section, biannual interim payments shall be calculated for each individual as the product of the average premium in the program for the period of time the individual was enrolled during that reporting period and one-half of the difference between the program's prior calendar year loss ratio and 110 percent. For subsequent reporting periods, the Managed Risk Medical Insurance Board may, by regulation, adopt for each health care service plan a specific method for calculating biannual interim payments based on the plan's actual experience in providing the benefits described in this section. Each health care service plan shall submit a six-month interim

report of monthly individual enrollment in its standard benefit plan. The Managed Risk Medical Insurance Board shall make an interim payment to each health care service plan pursuant to this section no later than 45 days after the receipt of the plan's enrollment reports. Final payment by the board or refund from the health care service plan shall be made upon the completion of verification activities conducted pursuant to this section.

(i) The provisions of this section constitute a pilot program that shall terminate on December 31, 2007.

(j) This section shall become inoperative on December 31, 2007, and as of January 1, 2008, is repealed, unless a later enacted statute that is enacted before January 1, 2008, deletes or extends the dates on which this section becomes inoperative and is repealed.

SEC. 2. Section 10127.15 of the Insurance Code, as added by Section 10 of Chapter 794 of the Statutes of 2002, is amended to read:

10127.15. (a) (1) This section shall apply only to a health insurer offering hospital, medical, or surgical benefits in the individual market in California and shall not apply to accident-only, specified disease, long-term care, CHAMPUS supplement, hospital indemnity, Medicare supplement, dental-only, or vision-only insurance policies or a health insurance conversion policy issued pursuant to Part 6.1 (commencing with Section 12670).

(2) A local initiative, as defined in subdivision (v) of Section 53810 of Title 22 of the California Code of Regulations, that is awarded a contract by the State Department of Health Services pursuant to subdivision (b) of Section 53800 of Title 22 of the California Code of Regulations shall not be subject to the requirements of this section.

(b) For the purposes of this section, "program" means the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)).

(c) (1) Each health insurer subject to this section shall offer a standard benefit plan. The calendar year limit on benefits under the plan shall be at least two hundred thousand dollars ($200,000), and the lifetime maximum benefit under the plan shall be at least seven hundred fifty thousand dollars ($750,000). No health insurer is required to provide calendar year benefits or

a lifetime maximum benefit under the plan that exceed these limits. In calculating the calendar year and lifetime maximum benefits for any person receiving coverage through a standard benefit plan, the health insurer shall not include any health care benefits or services that person received while enrolled in the program.

(2) The standard benefit plan of a health insurer participating in the program shall be the same benefit design it offers through the program, except for the annual limit required under paragraph (1). If the health insurer offers more than one benefit design in the program, it shall offer only one of those benefit designs as its standard benefit plan.

(3) (A) The standard benefit plan of a health insurer that is not a participating health plan within the program shall be any one benefit design that is offered through the program by a health care service plan participating in the program except for the annual limit required under paragraph (1).

(B) A health insurer that is not a participating health plan within the program that is under common ownership with, is affiliated with, or files consolidated income tax returns with, a health care service plan that is in the individual market, may satisfy the requirements of this section and Section 1373.62 of the Health and Safety Code if either the plan or insurer offers a standard benefit plan.

(C) A health insurer that is not a participating health plan in the program that is under common ownership with, is affiliated with, or files consolidated income tax returns with a health care service plan that is in the individual market and that is a participating health plan in the program is exempt from the provisions of this section if the plan meets the requirements of Section 1373.62 of the Health and Safety Code in offering a standard benefit plan.

(d) (1) A health insurer may not reject an application for coverage under its standard benefit plan for an individual who meets any of the following criteria:

(A) Applies for coverage within 63 days of the termination date of his or her previous coverage under the program if the individual has had continuous coverage under the program for a period of 36 consecutive months.

(B) Has been enrolled in a standard benefit plan, moves to an area within the state that is not in the service area of the health care service plan or health insurer he or she has chosen, and applies for coverage within 63 days of the termination date of his or her previous coverage.

(C) Has been enrolled in a standard benefit plan that is no longer available where he or she resides, and applies for coverage within 63 days of the termination date of his or her previous coverage.

(2) Notwithstanding any other provision of this section, a health insurer is not required by this section to accept an application for coverage under its standard benefit plan for any individual who is eligible for Part A and Part B of Medicare at the time of application and who is not on Medicare.

(e) The amount paid by an insured for the standard benefit plan shall be 110 percent of the contribution the insured would pay in the program for the benefit design providing the same coverage, using the same methodology in effect on July 1, 2002, for calculating the rates in the program. If a health insurer offers calendar year and lifetime maximum benefits in its standard benefit plan that exceed those in the benefit design offered through the program, it may not increase the amount paid by the insured for the standard benefit plan. The limitation on the amount paid by an individual pursuant to this section for a standard benefit plan shall not apply to any individual who is eligible for Part A and Part B of Medicare and who is not on Medicare solely because of end-stage renal disease.

(f) (1) Prior to offering a health insurance policy pursuant to this section, every insurer shall file a notice of any changes pursuant to Section 10290 and to Section 2202 of Title 10 of the California Code of Regulations. Prior to renewing a policy, the insurer shall file an amendment or notice of any changes, as appropriate, pursuant to Section 10290 and to Section 2202 of Title 10 of the California Code of Regulations.

(2) Prior to making any changes in the premium charged for its standard benefit policy, the insurer shall file an amendment in accordance with the provisions of Section 10290 and of Section 2202 of Title 10 of the California Code of Regulations.

(3) All other changes to an insurance policy that were previously filed with the commissioner shall be filed as

amendments in accordance with the provisions of Section 10290 and of Section 2202 of Title 10 of the California Code of Regulations.

(g) (1) Each health insurer shall report to the Managed Risk Medical Insurance Board the amount it has expended for health care services for individuals covered under a standard benefit plan under this section and the total amount of insured payments it has charged individuals for the standard benefit plan. The board shall establish by regulation the format for these reports. The report shall be prepared for each of the following reporting periods and shall be submitted within 12 months of the final date of the reporting period:

(A) September 1, 2003, to December 31, 2003, inclusive.

(B) January 1, 2004, to December 31, 2004, inclusive.

(C) January 1, 2005, to December 31, 2005, inclusive.

(D) January 1, 2006, to December 31, 2006, inclusive.

(E) January 1, 2007, to December 31, 2007, inclusive.

(2) "Health care services" means the aggregate health care expenses paid by the health insurer during the reporting period plus the aggregate value of the standard monthly administrative fee. Health care expenses do not include costs that have been incurred but not reported by the health insurer. The calculation of health care expenses shall be consistent with the methodology used on July 1, 2002, to calculate those expenses for participating health insurers in the program. The "standard monthly administrative fee" is the average monthly, per person administrative fee paid by the program to participating health insurers during the reporting period.

(3) The "total amount of insured payments" is the aggregate of the monthly insured payments charged by the health insurer during the reporting period. The calculation of the total amount of insured payments charged shall be consistent with the methodology used on July 1, 2002, to calculate subscriber contributions in the program. The Managed Risk Medical Insurance Board shall by regulation establish the format for submitting documentation of insured payments.

(4) The Managed Risk Medical Insurance Board may verify the health care expenses incurred by a health insurer and the insured payments received by the insurer. The verification shall include assurance that the insured was covered in the standard

benefit plan during the reporting period in which the health insurer paid health care expenses on the insured's behalf, and that the expenses reported are consistent with the standard benefit plan.

(h) (1) The program shall pay each health insurer an amount that is equal to one-half of the difference between the total aggregate amount the health insurer expended for health care services for individuals covered under a standard benefit plan who have had 36 months of continuous coverage under the program and the total aggregate amount of insured payments charged to those individuals who have had continuous coverage under the program for a period of 36 consecutive months. For purposes of determining the amount the program shall pay each health insurer, the total aggregate amount the health insurer expended and the total aggregate amount of individual payments shall not include amounts paid by or on behalf of an individual who is eligible for Medicare Part A and Medicare Part B and who is not on Medicare solely because of end-stage renal disease. The program shall make this payment from the Major Risk Medical Insurance Fund or from any funds appropriated in the annual Budget Act or by another statute to the program for the purposes of this section. The state shall not be liable for any amount in excess of the Major Risk Medical Insurance Fund or other funds that were appropriated for the purposes of this section. If the state fails to expend, pursuant to this section, sufficient funds for the state's contribution amount to any health insurer, the health insurer may increase the monthly payments that its insureds are required to pay for any standard benefit plan to the amount that the Managed Risk Medical Insurance Board would charge without a state subsidy for the same plan issued to the same individual within the program.

(2) The Managed Risk Medical Insurance Board shall make a biannual interim payment to each health insurer providing coverage pursuant to this section. For the first two reporting periods described in this section, biannual interim payments shall be calculated for each insured as the product of the average premium in the program for that period of time the individual was covered during the reporting period and one-half of the difference between the program's prior calendar year loss ratio and 110 percent. For subsequent reporting periods, the Managed

Risk Medical Insurance Board may, by regulation, adopt for each health insurer a specific method for calculating biannual interim payments based on the insurer's actual experience in providing the benefits described in this section. Each health insurer shall submit a six-month interim report of monthly insured enrollment in its standard benefit plan. The Managed Risk Medical Insurance Board shall make an interim payment to each health insurer pursuant to this section no later than 45 days after receipt of the insurer's coverage reports. Final payment by the board or refund from the insurer shall be made upon the completion of verification activities conducted pursuant to this section.

(i) The provisions of this section constitute a pilot program that shall terminate on December 31, 2007.

(j) This section shall become inoperative on December 31, 2007, and as of January 1, 2008, is repealed, unless a later enacted statute that is enacted before January 1, 2008, deletes or extends the date on which this section becomes inoperative and is repealed.

SEC. 3. Section 12712.5 of the Insurance Code is amended to read:

12712.5. (a) For the period commencing on September 1, 2003, to December 31, 2007, inclusive, the board shall maintain the major risk medical coverage benefits offered by participating health plans in the program at a level that is not less than the actuarial equivalent of the minimum benefits available within the program on September 1, 2002.

(b) This section shall become inoperative on December 31, 2007, and as of January 1, 2008, is repealed, unless a later enacted statute that is enacted before January 1, 2008, deletes or extends the dates on which this section becomes inoperative and is repealed.

SEC. 4. Section 12725 of the Insurance Code is amended to read:

12725. (a) Each resident of the state meeting the eligibility criteria of this section and who is unable to secure adequate private health coverage is eligible to apply for major risk medical coverage through the program. For these purposes, "resident" includes a member of a federally recognized California Indian tribe.

(b) To be eligible for enrollment in the program, an applicant shall have been rejected for health care coverage by at least one private health plan. An applicant shall be deemed to have been rejected if the only private health coverage that the applicant could secure would do one of the following:

(1) Impose substantial waivers that the program determines would leave a subscriber without adequate coverage for medically necessary services.

(2) Afford limited coverage that the program determines would leave the subscriber without adequate coverage for medically necessary services.

(3) Afford coverage only at an excessive price, which the board determines is significantly above standard average individual coverage rates.

(c) Rejection for policies or certificates of specified disease or policies or certificates of hospital confinement indemnity, as described in Section 10198.61, shall not be deemed to be rejection for the purposes of eligibility for enrollment.

(d) The board may permit dependents of eligible subscribers to enroll in major risk medical coverage through the program if the board determines the enrollment can be carried out in an actuarially and administratively sound manner.

(e) Notwithstanding the provisions of this section, the board shall by regulation prescribe a period of time during which a resident is ineligible to apply for major risk medical coverage through the program if the resident either voluntarily disenrolls from, or was terminated for nonpayment of the premium from, a private health plan after enrolling in that private health plan pursuant to either Section 10127.15 or Section 1373.62 of the Health and Safety Code.

(f) For the period commencing September 1, 2003, to December 31, 2007, inclusive, subscribers and their dependents receiving major risk coverage through the program may receive that coverage for no more than 36 consecutive months. Ninety days before a subscriber or dependent’s eligibility ceases pursuant to this subdivision, the board shall provide the subscriber and any dependents with written notice of the termination date and written information concerning the right to purchase a standard benefit plan from any health care service plan or health insurer participating in the individual insurance

market pursuant to Section 10127.15 or Section 1373.62 of the Health and Safety Code. This subdivision shall become inoperative on December 31, 2007.

SEC. 5. Item 4280-112-0236 is added to Section 2.00 of the Budget Act of 2006, to read:

4280-112-0236—For transfer by the Controller from the Unallocated Account, Cigarette and Tobacco Products Surtax Fund to the Major Risk Medical Insurance Fund, for the Major Risk Medical Insurance Program ..... (4,000,000)

SEC. 6. Notwithstanding any other provision of law, the Director of Finance shall make all necessary budgetary adjustments to implement this act. Within 30 days of making the adjustments, the Director of Finance shall notify the appropriate committees of the Legislature of these adjustments.

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Approved _____, 2006

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Governor